

ILLINOIS WIRELESS INFORMATION NETWORK - GROUPS REQUEST

Department Name: _____

IWIN Coordinator Name: _____

Name of Group to be created: _____

Name of users in group and the IWIN department they belong to:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

* Attach additional sheets as necessary.

If you have listed an IWIN user that is from a different department than yours, please have the IWIN coordinator from that department sign below:

IWIN Coordinator: _____ Department _____

IWIN Coordinator: _____ Department _____

IWIN Coordinator: _____ Department _____

IWIN Coordinator: _____ Department _____

IWIN Coordinator: _____ Department _____

Please return this form to:

CMS Communications Solution Center (CSC)
Attn: Provisioning
120 W. Jefferson, 2nd Floor
Springfield, Illinois 62702-5103
Fax: 217-524-5895 (for emergency orders only)

**For additional Information
contact the CSC
at 1-800-366-8768
(in centrex @217-524-4784)**